**INTRANSITE** Gel in the treatment of excoriated tissue.

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**Patient Two**

SC is a three-year-old girl who also suffers from cerebral palsy. She was admitted into the paediatric ward with a severe chest infection.

**The Nursing Challenge**

Manage tissue damage on a 3 year old girl with cerebral palsy.

**Nursing Aims**

- To use a treatment which would reduce excoriation.
- To use a wound care product which would provide the optimum environment for wound healing.
- To have an easy-to-use product for frequent utilisation.

**Nursing Interventions**

Having been prescribed antibiotic therapy she also presented with bouts of severe diarrhoea. SC’s parents were happy for INTRANSITE Gel to be used, as the barrier creams previously used had not been effective. The gel was applied onto the affected area in a similar way to a cream application.

**Outcome**

INTRANSITE Gel was applied to the affected areas over a six day period. Figure 3 shows the areas of excoriation prior to the use of INTRANSITE Gel. Picture 4 shows the results on the sixth day. By using INTRANSITE Gel a major improvement has been noted in the condition of SC’s skin.

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**General Conclusion**

One hopes by sharing two different patient profiles healthcare professionals will see a place for INTRANSITE Gel in the management of excoriation. By presenting these case studies, one can illustrate the benefits of using INTRANSITE Gel on excoriated skin.
An open evaluation of an enzymatic debrider, in combination with autolytic debridement in the management of wounds containing non-viable tissue.

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INTRODUCTION

Necrotic tissue can be a focus for infection and proliferation of bacteria, leading to a poor wound environment and compromised healing (Ref 1). Consequently, removal of devitalised tissue is important in promoting healing (Ref 2,3) and enzymatic debridement is an effective way of achieving this, especially in situations where surgical debridement is not possible or appropriate.

The aim of this study was to evaluate the ability of Collagenase (containing clostridiopeptidase A and associated proteases), in combination with IntraSite* Gel to debride necrotic wounds.

Patients were treated for up to 28 days, or until complete debridement was achieved. All wounds were treated with INTRASITE Gel and Iruxol** mono, covered with gauze. All dressings were changed on a daily basis.

RESULTS

Patient Details

Nineteen patients (13 female, 6 male) with a total of 30 wounds were treated in the evaluation. The mean age of the patients was 81.0 years (range 66-90).

Wound Details

<table>
<thead>
<tr>
<th>Wound Type</th>
<th>No. Wounds</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 4 pressure ulcer</td>
<td>21</td>
<td>Hip (7), sazum (4), heel (2), ankle (2), scapula (1), leg (1), knee (1)</td>
</tr>
<tr>
<td>Grade 3 pressure ulcer</td>
<td>7</td>
<td>Heel (4), ankle (2), knee (1)</td>
</tr>
<tr>
<td>VLU</td>
<td>2</td>
<td>Right leg (1), left leg (1)</td>
</tr>
</tbody>
</table>

Mean duration of wounds = 13.9 weeks (range 1-76 weeks)

Change in Wound Area

Mean wound area at baseline (cm²) = 27.6
Mean wound area at study completion (cm²) = 33.1

The increase in wound area can be attributed to the removal of necrotic tissue by the debriding activity of Iruxol mono.

Change in Exudate Level During Study Period

<table>
<thead>
<tr>
<th>Increased</th>
<th>Remained Same</th>
<th>Decreased</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/30 (26.7%)</td>
<td>12/30 (40%)</td>
<td>10/30 (33.3%)</td>
</tr>
</tbody>
</table>

Change in Pain Level During Study Period

<table>
<thead>
<tr>
<th>Increased</th>
<th>Remained Same</th>
<th>Decreased</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/30 (10%)</td>
<td>18/30 (60%)</td>
<td>9/30 (30%)</td>
</tr>
</tbody>
</table>

Debridement Efficacy

Mean % Non-Viable Tissue at Baseline = 89.6
Mean % Non-Viable Tissue at End of Study Period = 30.8
Mean % Reduction in Non-Viable Tissue = 58.8

7/30 (23.3%) of wounds were fully cleansed at study completion. For these wounds, mean time to debridement was 23.3 days (range 8-28 days).

CONCLUSION

The use of Iruxol mono and Intrasite gel in combination is an effective method of achieving wound debridement. In this evaluation, a mean reduction in non-viable tissue of 58.8% was achieved during the 28 day treatment period.

REFERENCES


Case Study 1 - Patient MGG

83 year old female with a grade 3 pressure ulcer of 8 weeks’ duration, on the left heel.
100% non-viable tissue at baseline (7% black necrosis, 93% yellow slough).
WOUND FULLY CLEANSED AT DAY 28

Case Study 2 - Patient ARP

66 year old female with a grade 4 pressure ulcer of 7 weeks’ duration, on the sacrum.
57% non-viable tissue at baseline (50% black necrosis, 7% yellow slough).
32% REDUCTION IN NON-VIABLE TISSUE AT DAY 29

Case Study 3 - Patient MLC

82 year old female with a grade 4 pressure ulcer of 8 weeks’ duration, on the left hip.
100% non-viable tissue at baseline (60% black necrosis, 40% yellow slough).
WOUND FULLY CLEANSED AT DAY 21

Case Study 4 - Patient SMS

80 year old female with a grade 4 pressure ulcer of 12 weeks’ duration, on the left hip.
35% non-viable tissue (yellow slough) at baseline.
WOUND FULLY CLEANSED AT DAY 8

* Trade Mark of Smith & Nephew  ** Trade Mark of Knoll AG, distributed by Smith & Nephew
Introduction
Caring for patients with a pressure ulcer can be a challenging prospect, particularly when the patient is elderly. This challenge can be further enhanced when the patient is recovering from a broken leg and subsequently experiences discomfort in turning and lying on the side of the injury.

The Patient
Mrs P, at the age of 92, was admitted to the nursing home from her own bungalow. A year before she fell and broke her right femur and was hospitalised. She was being treated at home receiving weekly visits from the district nurse for a leg ulcer. Mrs P had developed a small sacral pressure ulcer which resulted in her GP referring her to us.

On admission, Mrs P was assessed using the Waterlow risk calculator. Mrs P had a risk score of 19, classifying her in the ‘high risk’ category. She was nursed in bed on her left side, as it was painful to be nursed on the right side due to the break. An airflow mattress was in situ. We also felt as a team that Mrs P was undernourished and dehydrated, as a consequence blood was taken for assessment.

The Nursing Challenge
To manage a sacral pressure ulcer in an elderly patient.

Nursing Aims
■ To encourage healing without causing further damage to the wound.
■ To use a wound care product which would provide the optimum environment for wound healing.
■ To use a dressing which would be both easy to apply and remove, easing any associated pain.

INTRASITE* Conformable in the treatment of sacral pressure ulcers.

Dot Leader, Assistant Manager, Hassingham House Nursing Home, Hingham, Norfolk, NR9 4LR
Nursing Interventions

Intrasite Conformable was used as a primary dressing to gently pack the wound. A secondary dressing of Algisite M was applied and fixed into position. This regime was changed on a daily basis.

Over the period of the next five weeks (see Figs 1-5), the wound was successfully debrided and dressing changes then took place every second day.

Outcome

During the treatment, the dressings remained intact and no leakage of exudate occurred. The patient found the dressings comfortable and was therefore compliant to the treatment.

The nursing staff were able to apply and remove the dressings easily.

The wound was debrided easily and no pain was experienced during debridement.

Over the period of the case study, the cavity became noticeably smaller and should progress to healing.
**Nursing Interventions (continued)**

Having assessed the wound it was felt that the most appropriate dressing to use was a hydrogel. Intrasite Conformable was selected as the dressing of choice. Intrasite Conformable was laid over the area of eschar and was covered with non-adhesive Allevyn*. The aim of this dressing combination was to ensure that a moist wound environment can be created, which in turn would promote natural debridement through autolysis by gently rehydrating necrotic tissue.

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**Outcome**

Because of the unusual nature of the pressure ulcer the dressing was removed on the following day by the Clinical Nurse Specialist (see figure 3). The eschar had been rehydrated by the hydrogel and had undertaken a colour change. Five days later the wound was showing signs of granulation (see figure 4). Figure 5 shows the wound two weeks later when the pressure ulcer had nearly healed, the decision was made to discontinue the Intrasite Conformable and use non-adhesive Allevyn until the wound had completely healed.
**Introduction**

The management of babies with wounds can prove to be a challenge for nurses, this challenge can also be greater than before, when the aetiology of the wound is initially unclear.

**The Patient**

Baby P is a twin who was born 5 weeks premature. Twelve hours following the birth of Baby P an area of discoloration was noted on the nape of his neck (see figure 1). The nursing staff referred the patient to the Clinical Nurse Specialist as they had concerns as to how to manage the area of tissue damage. After lengthy discussions with numerous health care professionals it was agreed that the area was due to pressure damage caused by the position of Baby P’s twin sister prior to their birth.

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**The Nursing Challenge**

Manage a pressure ulcer in a difficult area on a pre-term baby.

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**Nursing Aims**

- To use a dressing which would rehydrate hard black eschar.
- To use a wound care product which would stay in contact with the wound.
- To provide the optimum environment for wound healing.
- To use a dressing which would be easy to remove.
- To use a dressing which would not cause any further damage to the baby’s fragile skin.
- To select a secondary dressing which would enhance the properties of the primary dressing.

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**Nursing Interventions**

Initially a hydrocolloid dressing was applied to the area of pressure damage as per the Trust’s wound care protocol. Despite using the dressing as per the manufacturer's instructions the wound presented with a hard black eschar when the dressing was removed by the Clinical Nurse Specialist a week later (see figure 2).
INTRASITE® Conformable in the treatment of necrotic pressure ulcers.

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Introduction

The presence of necrotic devitalised tissue on a wound bed can delay healing and also increases the risk of wound infection. Hydrogel effectively rehydrate devitalised tissue as the dressing facilitates the autolytic process allowing the separation of viable from non-viable tissue. Difficulties can be found when dressing awkward areas, as care must be taken to maximise the contact of the hydrogel with the wound, thus minimising the chance of the ‘squidge factor’ occurring.

The Patient

Glady is an 85 year old lady who was admitted to an acute medical ward having had a history of falls at home. She presented with a large necrotic pressure ulcer to her right heel (see figure 1).

The Nursing Challenge

To manage a necrotic pressure ulcer in an awkward area.

Nursing Interventions

Intrasite Conformable was opened out and placed over the area of the necrosis as per the manufacturer’s instructions (see Figure 2), and then covered with Allevyn® Heel dressing (see Figure 3). This ensures that maximum contact is made with the Intrasite Conformable and the wound. This dressing regime was carried out every three days. After 10 days the necrotic tissue had been rehydrated to allow sharp debridement to take place (see Figure 4). This procedure was carried out by the Clinical Nurse Specialist - Tissue Viability who has extensive expertise in this area (see Figure 5).

Intrasite Conformable continued to be used as previously described allowing debridement to be carried out at the weekly visit by the Clinical Nurse Specialist - Tissue Viability (see Figure 6).
INTRASITE* Conformable in the treatment of necrotic pressure ulcers.

Tracy Vernon, BA (Hons), RGN. CNS - Tissue Viability, Doncaster Royal Infirmary, Armthorpe Road, Doncaster, DN2 5LT

Nursing Aims

- To use a dressing which would rehydrate hard necrotic tissue.
- To use a dressing which would stay in contact with the wound.
- To provide the optimum environment for wound healing.
- To ensure maximum contact between the dressing and the wound interface.
- To select a dressing which would enhance the properties of the primary dressing.

Outcome

Sharp debridement is often viewed as being the quickest and most effective method of removing necrotic tissue. Initially this is not always an option when dealing with elderly, frail patients. Intrasite Comformable has proved to be effective in rehydrating necrosis allowing debridement to be carried out on a weekly basis. This has undoubtedly proved to be a positive outcome (see figure 7).
**Nursing Interventions (continued)**

The laparotomy wounds branched off in two directions across his abdomen. They looked red around the edges and large abdominal sutures were visible. The wound was closed at time of initial assessment.

Due to sloughy tissue and the levels of exudate we decided to start Vacuum Assisted Closure (VAC) as soon as possible to prepare for grafting (Fig 1b). The VAC therapy continued for two days. It was stopped on the second day due to a point of bleeding down in the groin. It was felt that the bleeding would probably continue as he was being anticoagulated at the time.

The wound looked cleaner and there was an obvious blood supply (Fig 2). The exudate levels remained high. The dressing used from then on was Intrasite Conformable, a new extension of an already popular dressing used widely throughout the Trust. This is a non-woven sheet impregnated with Intrasite hydrogel. This was chosen as Intrasite Gel would have been difficult to keep in situ in such a large wound.

**Outcome**

Within a week the wound was clean and granulating (Fig 3). Small areas of slough were lifting and softening and the dressing was comfortable and conformable. Dressing changes had reduced to once a day.
**Introduction**

The management of skin damage caused by necrotising fasciitis.

**The Patient**

PW is a 29-year-old window cleaner who fell 20 feet from a ladder. Upon impact he sustained a fractured wrist and crushed a large part of his liver. Following a laparotomy and partial lobectomy of the liver for tissue necrosis, he was transferred to the Bristol Royal Infirmary ITU for a further operation on his liver and specialist treatment for liver and kidney failure. Following this operation to stop bleeding internally and remove more necrotic tissue from the liver, he became pyrexial and generally more unwell. It was noticed on his flank a dusky hard area developing rapidly. Following further investigation necrotising fasciitis was diagnosed. He was taken back to theatre and the infection widely excised. Upon discussion with a neighbouring Trust, Betadine™ soaks and Jelonet® were commenced on the clean granulating wound.

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**The Nursing Challenge**

Manage a wound with necrotising fasciitis, to reduce and control exudation.

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**Nursing Aims**

- To use a dressing which would clean and lift areas of slough.
- To use a wound care product which would stay in contact with the wound.
- To provide the optimum environment for wound healing.
- To use a dressing which would be easy to remove.

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**Nursing Interventions**

The tissue viability project nurse was called in when the exudate levels were too much to cope with and dressing changes were two to three times a day. PW was intubated and unconscious at this time. On inspection of both wounds the fasciotomy wound (Fig 1a) was sloughy and exuding large amounts. A corrugated drain had been inserted into an old jejunostomy site and the drainage was soaking down into the wound itself. It was difficult to determine the tissue type in the wound due to the staining of the Betadine™ and the jaundiced colour of the patient himself.
Introduction

The management of tissue damage caused by excoriation of the skin as a result of urinary or faecal incontinence can be a challenge to nurses.

Patient One

RK is a 16-year-old girl who suffers from cerebral palsy, spastic quadriplegia, epilepsy and asthma. She is doubly incontinent as a result of her multiple pathological diagnosis. She was admitted to a paediatric ward within our Trust with a chest infection which proved to be Pseudomonas. Several days following admission RK was noted to have a red, excoriated anal area. She had been experiencing severe diarrhoea for some days as a consequence of the antibiotic therapy she had been prescribed. The nursing staff had been applying a barrier cream to the affected areas as this had previously been proven to be effective in the management of excoriated skin.

The Nursing Challenge

Manage tissue damage on a 16 year old girl with a multiple pathological diagnosis.

Nursing Aims

- To use a treatment which would reduce excoriation.
- To use a wound care product which would provide the optimum environment for wound healing.
- To have an easy-to-use product for frequent utilisation.

Nursing Interventions

The nursing staff referred RK to the Tissue Viability Nurse as there was not any sign of improvement following the use of the barrier cream. RK was already known to the Tissue Viability Nurse as she had been involved in RK’s care during her previous periods of admission. The Tissue Viability Nurse was able to explain to RK’s mother that INTRASITE Gel had been used for the treatment of excoriation in other patients with excellent results. RK’s mother consequently gave permission on behalf of RK to use INTRASITE Gel.

Outcome

The nursing staff applied the INTRASITE Gel over the affected area as shown in Figure 1. The INTRASITE Gel was reapplied following the cleansing of the skin every two hours or after each episode of faecal or urinary incontinence. Figure 2 shows a dramatic change in the condition of RK’s skin. INTRASITE Gel had been used as indicated above for a period of three days.